

# Preparticipation Physical Evaluation

**Revised 7/1/05  
Mandatory**

Date of Exam \_\_\_\_\_

**HISTORY FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_ Sport (s) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal Physician \_\_\_\_\_

**In case of emergency, contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

**Explain "Yes" answers below.  
Circle questions if you do not know the answers.**

Yes No

Yes No

- |  |            |          |           |           |           |                  |                  |       |            |            |     |       |      |           |       |               |   |
|--|------------|----------|-----------|-----------|-----------|------------------|------------------|-------|------------|------------|-----|-------|------|-----------|-------|---------------|---|
| <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or non-prescription (over the counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Has a doctor ever told you that you have (check all that apply):<br/> <input type="checkbox"/> High blood pressure      <input type="checkbox"/> A heart murmur<br/> <input type="checkbox"/> High cholesterol          <input type="checkbox"/> A heart infection</p> <p>10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative died of heart problems or sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 2px;"> <p>17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="font-size: small;">Head</td> <td style="font-size: small;">Neck</td> <td style="font-size: small;">Shoulder</td> <td style="font-size: small;">Upper Arm</td> <td style="font-size: small;">Elbow</td> <td style="font-size: small;">Forearm</td> <td style="font-size: small;">Hand/<br/>Fingers</td> <td style="font-size: small;">Chest</td> </tr> <tr> <td style="font-size: small;">Upper Back</td> <td style="font-size: small;">Lower Back</td> <td style="font-size: small;">Hip</td> <td style="font-size: small;">Thigh</td> <td style="font-size: small;">Knee</td> <td style="font-size: small;">Calf/Shin</td> <td style="font-size: small;">Ankle</td> <td style="font-size: small;">Foot/<br/>Toes</td> </tr> </table> </div> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | Head       | Neck     | Shoulder  | Upper Arm | Elbow     | Forearm          | Hand/<br>Fingers | Chest | Upper Back | Lower Back | Hip | Thigh | Knee | Calf/Shin | Ankle | Foot/<br>Toes | <p>24. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Do you have headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you happy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommended that you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>FEMALES ONLY</b></p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 months? _____</p> |
| Head   | Neck       | Shoulder | Upper Arm | Elbow     | Forearm   | Hand/<br>Fingers | Chest            |       |            |            |     |       |      |           |       |               |   |
| Upper Back   | Lower Back | Hip      | Thigh     | Knee      | Calf/Shin | Ankle            | Foot/<br>Toes    |       |            |            |     |       |      |           |       |               |   |

**Explain "Yes" answers here:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of Athlete \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# Preparticipation Physical Evaluation

PHYSICAL EXAMINATION

DATE OF EXAM \_\_\_\_\_

This page to be completed by physician/nurse practitioner/physician assistant.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_

Vision R 20 / \_\_\_\_\_ L 20 / \_\_\_\_\_ Corrected? Y N Pupils - Equal \_\_\_\_ Unequal \_\_\_\_ Hearing \_\_\_\_

	NORMAL	ABNORMAL FINDING	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*Station-based examination only

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Not cleared for [Sport(s)]: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of physician/nurse practitioner/physician assistant (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Telephone \_\_\_\_\_

Signature of physician/nurse practitioner/physician assistant: \_\_\_\_\_

MD/nurse practitioner/physician assistant

Physician's Stamp

PARTICIPATION PHYSICAL EVALUATION (MONOGRAPH). KANSAS CITY, MO: AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN MEDICAL SOCIETY FOR SPORTS MEDICINE, AMERICAN ORTHOPAEDIC SOCIETY FOR SPORTS MEDICINE, AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE, 1992, 1996

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